NEWSLINK

Volume 2 – Issue 1 **Published by the Virginia Board of** **May, 2000**
Licensed Professional Counselors, Marriage and Family Therapists,
and Substance Abuse Professionals

Calendar of Upcoming Events

July 15, 2000
Examination: Licensed Professional Counselor

August 24, 2000
Committee meetings - Richmond
Regulatory, Examination , Supervision, Credentials

August 25, 2000
Board Meeting - Richmond

October 21, 2000
Examination: Licensed Professional Counselor

October 28, 2000
Examination: Certified Substance Abuse Counselor
Examination: Certified Rehabilitation Provider

November 3, 2000
Examination: Marriage and Family Therapists

November 8, 2000
Committee meetings - Richmond

November 9, 2000
Board Meeting - Richmond

From the Editor...

By Eric Scalise – Chair, Public Relations Committee

Time marches on. It can't be stopped or controlled but we can learn to manage it better. Like paddling a kayak in the middle of raging rapids, sometimes the best we can do is to go with the flow, try to avoid the boulders and enjoy the ride. There may be uncertainties ahead but it is the great adventure of living that causes us to seek the next bend in the river.

We have not only entered a new year, but a new decade, a new century and a new millennium as well. Talk about closure and new beginnings! It was this past century that gave rise to the birth of our profession. The evolution of behavioral medicine, psychotherapy, family systems and substance abuse treatment can be seen in the forces that have shaped and defined our society and culture. While human nature remains much the same as it always has, the therapeutic community requires ever constant flexibility and adaptation.

(Continued on page 3)

Board Information

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Committee Assignment: Regulatory
& Examination Committees

Timothy E. Clinton, Ed.D., LPC
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President, Light Associates, Inc.
1st term; expires 6/30/00
Committee Assignment: Supervision

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Richmond, VA
Associate Pastor, Bon Air Baptist
1st term; expires 6/30/01
Committee Assignment: Credentials
& Examination Committees

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Emory, VA
Citizen member
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Committee Assignment: Legislation

Rosemarie S. Hughes, Ph.D., LPC
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Regent University; Dean of
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2nd term; expires 6/30/03
Committee Assignment: Executive
& Regulatory Committees

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Clinical Manager; Hampton-Newport
News Community Service Board
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Committee Assignment: Executive

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Hampton University, Asst. Professor
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Committee Assignment: Credentials
& Supervision Committees

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2nd term; expires 6/30/00
Committee Assignment: Discipline

From the Editor... —

(Continued from page 1)

Given that the only constant there is seems to be more change, we must continue to evaluate our purpose and goals while considering the needed mid-course corrections to achieving their ends. Most of us entered this field with a desire and determination to make a difference in the lives of those around us and to the communities we are a part of. It is with that same call to service that the Board looks toward another year. Though its members come and go, agendas written and rewritten, issues addressed and resolved, what makes the most significant difference is the collaborate effort of all of us. For each bit of input that we receive from a person, we realize it may represent dozens, perhaps hundreds of similar opinions. We would like to invite you to the table and to the process of growing our profession towards greater excellence.

The Board would also like to recognize and express its deepest thanks to Michael Kelly, our outgoing Board Chairman. He has served this Board with consistent effort and dedication for the past eight years. His leadership was critical in the transitions of the past several years. This includes accommo-dating the growth of the Board membership and in addressing the issues surrounding two new licenses (Marriage & Family Therapist and Licensed Substance Abuse Treatment Practitioner).

We also welcome our new Chair, Susan Leone and are looking forward to serving you together this year. As always, please feel free to share your ideas and feedback regarding the newsletter.

Regulatory Review

By Dr. Rosemarie S. Hughes, Regulatory Committee Chair

In the past year, the Board completed extensive reviews of several of its regulations, and established new regulations for licensure of substance abuse treatment practitioners. Highlights of the new regulations and amendments to existing regulations are:

Substance Abuse Treatment Practitioner Licensure

The requirements include a master's degree in substance abuse treatment or a related counseling discipline, 60 graduate semester hours covering a general counseling core curriculum and five substance abuse competencies, and a passing score on the Master's Addictions Counselor (MAC) examination. The Board now has a contract to administer the MAC exam to its applicants. Individuals who already hold a mental health license (which required a master's degree and 60 graduate hours) may be eligible for licensure without examination if they can also document:

- Current Board certification as a substance abuse counselor with 2 years of post-licensure or certification substance abuse experience.
- A national certification in substance abuse treatment acceptable to the board.
- Five years of post-licensure substance abuse experience, plus 12 credit hours of didactic training in the five substance abuse competencies. If the master's degree was in substance abuse, only two years of post-licensure experience are needed.

To request an application package, contact the Board office at 804/662-9912. In addition, regulations and application forms are accessible on the internet at www.dhp.state.va.us.

In response to 1999 legislative mandate to develop an equivalency for individuals who do not meet all of the requirements in the regulations, the Board has submitted a request to the Administration for permission to amend the regulations. The Board has not yet received permission to begin the regulatory process, but has received substantial public comment, both in favor of and in opposition to the preliminary proposal. The progress of the Board's regulatory work can be tracked on Virginia's Regulatory Townhall at www.townhall.state.va.us.

Professional Counselor Licensure

- The education requirement was updated for the first time in 20 years to include courses in addictions, research, multicultural counseling and marriage and family systems theory, with a 3 semester hour minimum for all required coursework. To accommodate students currently enrolled in a degree program, the

Board has delayed the effective date for the new coursework until April 12, 2002. Individuals who complete the 60 graduate hours prior to that date may be accepted under the requirements in effect at the time the coursework was completed.

- Graduate internship hours that meet certain requirements will be accepted toward the residency requirement for up to 600 hours (up to 900 hours for CACREP or CORE approved programs).

- Group supervision hours are now accepted as equivalent to face-to-face hours, for up to half of the 200 required hours. The face-to-face requirement has been changed from 1 hour per week to 1 hour per 20 hours of work experience to accommodate individuals who are working part-time toward the residency. In addition, the regulation now specifies a 2000 client contact hour requirement within the 4000 hour residency. Supervisors must now attest to two years of post-licensure clinical experience prior to initiation of the residency, and provide quarterly evaluation reports to their residents, to be turned in at completion of the residency. Individuals who registered their residency prior to April 12, 2000 will be held to the regulations in effect at the time they registered.

- A process was established for endorsement without examination of practitioners licensed in other states by requirements equivalent to those in the Board's regulations.

Substance Abuse Counselor Certification

- Individuals who are certified as substance abuse counselors with two years of post-certification work experience in substance abuse may now act as supervisors without also having a national certification in substance abuse.

- Group supervision hours are now accepted as equivalent to face-to-face hours, for up to half of the 200 required hours. The face-to-face requirement has been changed from 2 hours per week to an *average* of 2 hours per week.

Marriage and Family Therapy License

- The semester hour requirement in marriage and family studies and marriage and family therapy has been reduced from 9 semester hours to 6 semester hours in each area. A 3 semester hour minimum has been included for each core area.

A provision has been included to allow applicants whose graduate programs did not contain all core areas to obtain needed training outside the program.

- Graduate internship hours that meet certain requirements will be accepted toward the residency requirement for up to 600 hours.
- Group supervision hours are now accepted as equivalent to face-to-face hours, for up to half of the 200 required hours. In addition, the regulation now specifies a 2000 client contact hour requirement with 1000 hours in direct contact with couples or families within the 4000 hour residency.

In addition to the changes in requirements, fees have changed for all the Board's licensure and certification categories. The changes have been made in accordance with principles which are being applied to all boards in the agency, and have resulted in greater consistency among the three licensure and two certification categories. For professional counselor licensure and substance abuse counselor certification, renewal fees have returned to approximately the pre-1997 levels, and will be due annually after the next renewal date of June 30, 2001. The late renewal period has been standardized to one year, after which a reinstatement application and fee must be submitted. This eliminates the need to pay cumulative renewal and penalty fees for individuals who are returning to Virginia after a lengthy absence.

Legislation has passed the General Assembly which will change the name of the Board to the *Board of Counselors*. The new name will take effect July 1, 2000. The Regulatory Committee will be working on several issues in the coming year. In addition to the equivalency requirements for substance abuse treatment practitioner licensure mentioned previously, the Committee will continue studying the adequacy of the education requirement for substance abuse counselor certification, working toward consistency in the language among its regulations, and developing an inactive licensure status for individuals who are not actively practicing in Virginia.

Statistical Information

Total Number of Licensees/Certificate Holders as of March 1, 2000

Licensed Professional Counselors	2,310

Licensed Marriage and Family Therapists	902
Certified Substance Abuse Counselors	1,124
Certified Rehabilitation Providers	846
Licensed Substance Abuse Treatment Practitioners	5

Results of April 24, 1999 LPC Examination

Number examined	55
Number passed	44 (80%)

Results of October 23, 1999 LPC Examination

Number examined	63
Number passed	52 (83%)

Results of May 14, 1999 LMFT Examination

Number examined	2
Number passed	2 (100%)

Results of November 12, 1999 LMFT Examination

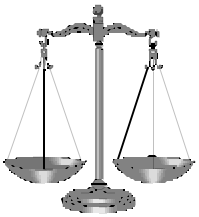
Number examined	2
Number passed	2 (100%)

Results of April 24, 1999 CSAC Examination

Number examined	58
Number passed	45 (78%)

Results of October 23, 1999 CSAC Examination

Number examined	63
Number passed	52 (83%)



Disciplinary Actions

The Board has taken the following disciplinary actions since January 99:

JAMES A. LaCOURSIERE # 0701-001589

FINDINGS: During the course of counseling a client for issues related to post traumatic stress due to childhood physical and sexual abuse, he failed to maintain appropriate therapeutic boundaries in that he hugged the client and massaged her shoulders and back and additionally failed to refer the client when he became aware that her treatment needs were beyond his level of competence.

ACTION: License placed on indefinite probation with terms and conditions requiring supervision of practice and specific additional training. Order entered March 26, 1999.

GLORI L. SAVIN, POST GRADUATE TRAINEE

FINDINGS: Entered into a dual relationship with her supervisor in that she failed to disclose on her application for supervision that her supervisor was her mother.

ACTION: Reprimand imposed and disallowance of all supervision hours completed with her mother as supervisor. Order entered June 23, 1999.

General Assembly 2000

The following bills have been enacted and will be become law July 1, 2000:

HB253 which changes the name of he Board of Licensed Professional Counselors, Marriage and

Family Therapists and Substance Abuse Counselors to the Board of Counseling.

HB677 requires any mental health service provider

who learns of evidence that indicates a reasonable probability that another mental health provider is or may be guilty of a violation of standards of conduct to advise his patient of the right to report such information to the Department of Health Professions. The mental health service provider must provide the patient with information, including, but not limited to, the Department's toll-free complaint hotline number for consumer complaints and written information published by the Department of Health Professions, explaining how to file a report. The mental health service provider must also document in the patient's record the alleged mis-conduct, the category of licensure or certification and approximate dates of treatment, if known, of the provider who will be the subject of the report, and the action taken by the mental health service provider to inform the patient of his right to file a complaint with the Department of Health Pro-fessions. The mental health service provider will be immune from any civil liability or criminal pro-secution resulting therefrom unless such person acted in bad faith or with malicious intent. Any person failing to inform a patient of his right to file a complaint against a regulated person as provided in this bill will be subject to a civil penalty not to exceed $100 dollars.

HB810 requires a health care provider to accept a photocopy, facsimile, or other copy of the original document signed by the patient providing authority for the requester to obtain his health care records.

SB529 requires the medical director who is the employee of a utilization review organization to be licensed to practice medicine in the Commonwealth. It also clarifies that a "peer of a health care provider" and a "physician advisor" be licensed in

the Commonwealth or in another state with comparable requirements to Virginia.

Liability, Ethics and the Law

By Lynne Fleming, Attorney General's Office

Maintaining Client Records

Virginia Code § 54.1-2403.3 states that:

> **Medical records maintained by any health care provider as defined in § 32.1-127.1:03 shall be the property of such health care provider or, in the case of a health care provider employed by another health care provider, the property of the employer. Such health care provider shall release copies of any such medical records in compliance with § 32.1-127.1:03 or § 8.01-413, if the request is made for purposes of litigation, or as otherwise provided by state or federal law.**

The definition of "provider" in Virginia Code § 32.1-127.1:03 includes, in relevant part, "all persons who are licensed, certified, registered or permitted by any of the Health Regulatory Boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine."

Virginia Code § 32.1-127.1:03, captioned "Patient health records privacy," is a lengthy statute which establishes requirements for release of records in connection with requests from patients, requests from third parties and subpoenas. In general, the law requires that, upon the written request of a patient, the provider must, within 15 days, provide a copy of the patient's records, inform the patient that the records do not exist or cannot be found, direct the patient to the provider who is maintaining the patient's records or, if the provider is the patient's attending physician or the patient's clinical psychologist, inform the patient that the request is being refused because furnishing the records "would be injurious to the patient's health or well-being." The statute additionally states that the provider shall not disclose the patient's records without the consent of the patient, except as permitted by law. The statute then lists 24 permissive exceptions to this disclosure limitation and specifies the method by which records are to be produced in response to a subpoena. Finally, the statute permits release of patient records in compliance with other state and federal laws.

All providers should be familiar with the general provisions of this statute and its permissive exceptions to the general rules. However, because this statute was discussed in detail in a previous edition of this newsletter, this article will focus on other statutory provisions relevant to patient records.

Other statutory provisions pertinent to patient records:

Virginia Code § 54.1-2405 provides that No person licensed, registered, or certified by one of the health regulatory boards under the Department [of Health Professions] shall transfer records pertaining to a current patient in conjunction with the sale of a professional practice until such person has first attempted to notify the patient of the pending transfer, by mail, at the patient's last known address, and by publishing prior notice in a newspaper of general circulation within the provider's practice area. The notice shall specify that, at the written request of the patient or an authorized representative, within a reasonable time period, the records or copies will be sent to any other like-regulated provider of the patient's choice or destroyed.

The above provision is applicable only to the "sale" of a professional practice, but there is nothing that would prohibit following the procedure outlined in the case of the closing, without a sale, of a practice. Virginia Code § 54.1-111(C) states that it is not unlawful for the owner of patient records to retain copies of his patient records or prescription dispensing records after the closing of a business or professional practice or the transfer of ownership of a business or professional practice. This latter section also allows the provider to charge a "reasonable fee," not in excess of fifty cents per page for up to fifty pages and twenty-five cents a page thereafter for copies from paper and one dollar per page for copies from any micrographic process, plus postage and shipping costs and a search and handling fee not to exceed ten dollars.

Virginia Code § 54.1-2403.2 permits the storage of patient records by "computerized, or other electronic process or microfilm, or other photographic, mechanical, or chemical process" and, if such process creates an "unalterable record," the

provider is not required to maintain paper copies of the records stored by such process. When the technological storage is completed, the paper copies of medical records may be destroyed "in a manner that preserves the patient's confidentiality."

Upon the request of any of his patients, a provider is required to provide to the patient an itemized statement of the charges for the services provided to the patient, regardless of whether a bill for the services which are the subject of the request has been or will be submitted to any third party payor. *See Va. Code § 54.1-2404.*

The Department of Health Professions has statutory authority to subpoena patient records from any provider in connection with a complaint investigation into actions either by the subpoenaed provider or any other provider. *See Va. Code § 54.1-2506.* One of the permissive exemptions in the patient health records privacy act, Virginia Code § 32.1-127.1:03 discussed above, permits the disclosure of patient records in connection with Virginia Code § 54.1-2506 or any investigation by a "law enforcement, licensure, accreditation or professional review entity." *See Va. Code § 32.1-127.1:03(D.)(3), (6).* Failure to provide records or other documents requested by a health regulatory board is an "unlawful act," punishable as a Class 1 misdemeanor. *See Va. Code § 54.1-111(A.)(7).*

No Virginia statute establishes a general requirement for maintaining patient records for a specified length of time. Individual health regulatory boards may have such requirements in their regulations. {The Virginia Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Professionals requires that all licensed

professional counselors, marriage and family therapists and substance abuse treatment practitioners regulated by the Board maintain patient records for not less than five years post-termination. *See 18 VAC 115-20-130, 115-50-110, 115-60-130) .*

In addition to the brief discussion of the patient health records privacy act, this article has addressed only those Virginia statutes which appear in Title 54.1 of the Code of Virginia which establishes a system for regulation of health care professionals. Federal laws, such as 42 U.S.C. 290dd-2 which governs records of patients treated for substance abuse, supercede Virginia statutes and regulations.

Other Virginia statutes may have limited application to specific situations, such as criminal cases. If a provider has questions about producing or maintaining patient records, the provider may wish to discuss such issues with his attorney. If the questions
involve regulations of a health regulatory board or statutes applicable to the regulated profession, the provider may contact the Board.

Practice Issues and Strategies

False Memory Syndrome

By J. Steve Strosnider, LPC

False memory syndrome is a complex issue for which there are no easy answers. Corroborating evidence is often lacking and human beings often have distorted memories. There also may be other circumstances which may have an effect upon the phenomenon including secondary gain for the patient, pathological motivations of the patient, dynamics of the perpetrator, and non-therapeutic or unhealthy motivations of the psychotherapist. Trying to figure out what really happened can be a nightmare.

Essentially, there are three types of false memory.

1. *False positive* - An individual recovers or remembers an event that did not occur.
2. *False negative* - An individual has no memory for an event that indeed did occur.
3. The *false memory* of a perpetrator which may have been tainted by the proclivity to engage in denial, rationalization, and externalization, character disorder, or a memory obscured by the effects of drugs or alcohol.

During the 1980s, in an effort to accommodate individuals who felt they were the victims of abuse through the recovering of past memories, at least 21 states altered their laws to allow an extension of the statute of limitations to allow for civil or criminal charges to be brought against alleged perpetrators. In some states, a plaintiff may bring legal action against alleged sexual abuse perpetrators up to 2-3 years after he or she recovers memories of the abuse which may be decades after the actual events. These developments coupled with increased media cover-age and the formation of advocacy groups such as the False Memory Syndrome Foundation have increased the public and professional awareness of the issue.

One of the main problems in determining the

authenticity of recovered memory is the fact that there is no specific constellation of symptoms which would definitively indicate the recovered memories as a factor in the development of pathology. The medical model concept of illness is that the illness is known to have a specific etiology, course of treatment, and prognosis. Psychotherapy is an inexact science. The medical model often does not apply to patients with a bonafide history of sexual abuse who may present the same constellation of symptoms as a patient who does not have a history of sexual abuse.

Review of Research

There is a great deal of controversy regarding the intangible constructs such as repression and disassociation which lie at the premise of clinical assumptions with regard to recovered memories. The research literature on repression is complex and exceedingly controversial. Two influential reviews of the research literature with regard to repression present diametrically opposite conclusions.

Disassociation is defined as "specific memories which are inaccessible because they are associated with a highly charged event." In disassociation, the event is encoded, but not readily retrieved. While acceptance of the concept of repression assumes acceptance of a psychodynamic approach with regard to unconscious defense mechanisms, disassociation has been demonstrated to occur and is not tied to any psychotherapeutic assumptions. Disassociation has been implicated in the acquisition, storage, and retrieval of memory with regard to trauma. Being exposed to trauma has been shown to increase the prevalence of dissociative symptoms.

These symptoms include alterations of memory. The consensus among experts is that dissociative symptoms can be expected in a relatively large portion of a population who may be exposed to a traumatic event. According to this model, disassocation acts as a coping strategy for dealing with the intolerable event.

By definition, trauma is a human experience so overwhelming that it is difficult to face and integrate psychologically. Literature on trauma contains a great deal of evidence regarding pathologies of memory in response to trauma. These include total amnesia with regard to the trauma, or preoccupation with the trauma (frequent intrusive thoughts). In others, partial or fragmentary memory is found. It is also apparent that traumatic memory often lacks coherence and proper chronology. Alterations of memory have been reported for victims of a wide range of trauma including natural disasters, rape, war, physical and sexual abuse, kidnapping, torture, and concentration camp experiences. A significant amount of data has been collected suggesting that memory for traumatic events may be encoded differently than memory for unremarkable events; however, while some factors likely exacerbate the forgetting of childhood traumas, others are likely to preserve the memories. Research on autobio-graphical memory suggests that people who were sexually abused in the first few years of life are unlikely to remember the experiences as adults. Those that experienced one or few isolated instances of abuse may often not remember the events as adults; however, research evidence regarding adults with extreme histories of sexual abuse who recover the memories under therapeutic conditions suggests that this is a rare phenomenon.

It is now clear human memory is not a pristine, perfect form. It is not readily available like a VCR tape to be played at will. Indeed, the memory itself, the organization of that memory, and its details are highly dependent upon any number of factors. Essentially, a memory can be divided into four stages: Encoding, Storage, Retrieval and Recounting. All of these processes can be influenced by a variety of factors including developmental stage, expec-tations and knowledge prior to an event, stress and bodily sensations experienced during an event, postevent questioning, and the experience of recounting the event. In addition, the retrieval and recounting of a memory can modify the form of the memory which may influence the content and the conviction about the veracity of the memory.

An objective review of all available literature with regard to childhood sexual abuse and trauma suggests that:

1. Most victims remember their traumas:
2. True amnesia for traumatic events can occur, but is rare;
3. Only a small percentage of people have hidden memories of abuse that they can recover through memory work;
4. Poor memory for childhood events is normal.

Role of the Counselor

At the risk of being overly simplistic, psychotherapists with a psychodynamic approach

operate on the assumption that unresolved issues, mostly unconscious to the patient, when discovered, reworked, and placed in perspective will lead to a reduction in the patient's symptomatology. What is known, however, is that insight in and of itself does not necessarily lead to behavioral change. There is, however, ample research evidence that expressive psychotherapies are beneficial. Outcome psychotherapy research demonstrates that it is helpful for patients to reflect on their present feelings and their past in a disciplined and compassionate therapeutic milieu. It is helpful for patients to have at least an intellectual awareness of how historical events have shaped their behaviors in the present. As such, what patients learn about their past may be helpful; but it does not necessarily mean that it is an accurate representation of their past. There is oftentimes the assumption on the part of psychotherapists that patients are expressing something that has been there all along and somehow hidden. The therapist then sees as his or her task the "uncovering" of past events. Psychotherapy would be far easier and even more therapeutically successful if after simply uncovering the past memory it would liberate the patient from the symptoms. Unfortunately, this is not the case.

Some memory-work therapists feel that taking legal action is therapeutic in that patients gain a sense of empowerment, validation, and healing. Other therapists feel that legal actions against alleged perpetrators do more harm than good. It is recommended that counselors are obliged to warn patients about the risks of memory recovery techniques and seek corroborative evidence to support the allegations, especially if legal actions are pursued.

Recommendations for Counselors

1. The therapist should maintain an empathic, non-judgmental and neutral stance toward reported memories of sexual abuse. The therapists must remind themselves that their's is the job of being a therapist and not of a judge or jury. It is not the job of the therapist to determine the authenticity of the patient's reports. Expression of disbelief on the part of the therapist is likely to cause the patient further pain and decrease his/her willingness to seek help. Open skepticism on part of the therapist once again sets into motion the dynamic of others discounting or denying that the patient's abuse occurred.

2. A careful history should be taken from all patients and questions about the entire range of risk factors, including but not limited to, a history of sexual abuse should be asked. Questions should be phrased in a non-leading manner and in the most open way possible.

3. When patients report uncovered memories of previous abuse, therapists should take a number of steps to avoid imposing a particular version of reality to reality to reduce the risk of creating false memories.

4. The first goal of treatment should be stabilization and containment. This is done through symptom reduction and the development of coping skills. It is important to remember that the goal of psychotherapy is not detective work. The recollection of trauma helps only in so far as it is integrated into therapy emphasizing the improvement of functioning.

5. In dealing with recovered memory, therapists should carefully consider all alternative hypotheses including: (A) the retrieved material is accurate; (B) that it is distorted memory of real events; (C) that it is a confabulation emerging from underlying psychopathology or difficulties with reality testing; or (D) that it is a pseudo-memory engaging from exposure to suggestions.

6. The use of hypnosis as a means of retrieving or confirming recollections of the past is not an appropriate procedure for this goal because of the serious risk that pseudomemories may be created in trance-like states, and the related risk due to increased confidence in those memories as a result of hypnosis.

7. Therapists should use a great deal of caution with regard to making assertions to legal authorities as to the factual basis of recent recollections. Therapists should explore a variety of other alternatives with the patient before embarking on a course of confrontation with family members or legal authorities.

8. Therapists should explore with the patient who reports recovering memory of childhood abuse the meaning and implication of the memory rather than focusing solely on the content or validity of the report.

9. Patients should be told that memory is not stored like a VCR tape and that memories may not always be accurate. Human memories are not like fixed images in a family photo album.

10. Therapists should be sensitive to the issue of responsibility. Many patients have feelings of being responsible for having been victimized. It is important to reframe this and put the responsibility for the actions on the perpetrator. While the patient was not responsible for what went on at the time, it is important that the patient be told they can and should take responsibility for caring for themselves in the present and in the future.

11. Therapists should be aware that the recovery of past trauma helps victimized patients to have a sense of personal history and to understand how the trauma affects their lives in the present. It is the reframing and understanding of the role of trauma in their lives that helps traumatized people to move on.

12. It is important to caution the patient with recovered memory against making any major life decisions during the acute phase of treatment. Breaking off relationships with important attachment figures, pursuing legal actions, and the making of public disclosures may need to be addressed. The therapist must sensitize the patient to the emotional impact of making such decisions.

13. Adequate records should be maintained. The documentation should reflect a process related to the assessment and ongoing treatment and should document facts and descriptions about what takes place in the therapeutic setting. Notes

should also reflect how the memories surfaced and how the client arrived at the conclusion that he or she was the victim of child or sexual abuse.

14. Therapists should be knowledgeable of state and federal laws regarding disclosure, reporting of abuse, privileged communication, and release of records.

15. Denial on behalf of an alleged perpetrator is a common-place phenomenon; however, the therapist must remember that without corroborative evidence, no one knows for sure

STAFF

Evelyn B. Brown, Executive Director

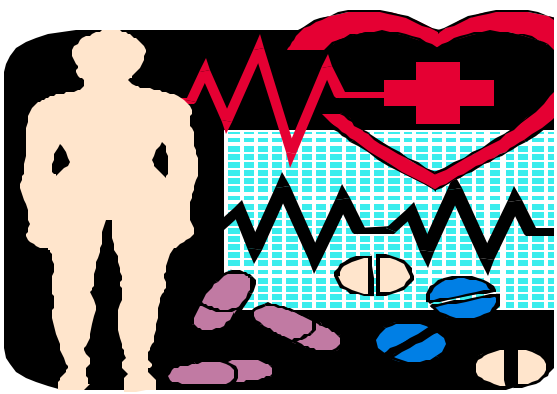
- Also Executive Director for Boards of Social Work and Psychology
- Oversees adjudication, rule-making, legislative proposals, examinations & licensing

Janet D. Delorme, Deputy Executive Director

- Manages regulatory & legislative process and research for all behavioral science boards
- Develops application procedures for new programs

Joyce Williams, Administrative Assistant

- Reviews and processes applications and residency registrations for licensed MFT, SATP and Certified Rehabilitation Providers
- Coordinates application review for LPC & CSAC and examinations for all categories of licensure certification
- Coordinates disciplinary hearings, manages probation and sanctions



Practitioner Intervention Health Program

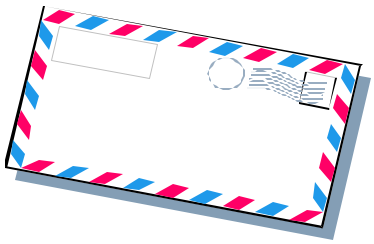
In January of 1998, the Health Practitioners' Intervention Program became available to any person who is or was licensed, certified, registered or an applicant under a health regulatory board. Through Virginia Monitoring Inc., the Program provides confidential assessment, evaluation and referral services for impaired practitioners. Information concerning the Health Practitioner's Intervention Program may be obtained from:

William E. McAllister
Virginia Monitoring, Inc.
2101 Executive Drive, Suite 5M – Tower Box 88
Hampton, VA 23666
(757) 827-6600
(888) 827-7559 (answered 24 hours a day)
FAX: (757) 827-8864

Copies of the statutes and regulations governing the Health Practitioners' Intervention Program are available from the Virginia Department of Health Professions.

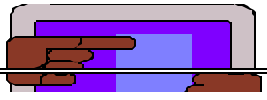
INTERVENTION PROGRAM COMMITTEE COORDINATOR
VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

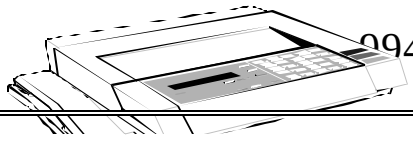
Ms. Donna P. Whitney, LPN, CSAC
6606 WEST BROAD STREET, 4th FLOOR
RICHMOND, VIRGINIA 23230-1717
TELEPHONE (804) 662-9424
FAX (804) 662-9943
e-mail d.whitney@dhp.state.va.us



Name and Address Changes

Board policy requires that all name and address changes be made in writing to the Board office. In the case of name change, a copy of the official document indicating the change is required. You can also FAX or e-mail the necessary information to the Board Office at:





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VIRGINIA BOARD OF LCIENSED PROFESSIONAL COUNSELORS MARRIAGE AND FAMILY THERAPISTS AND SUBSTANCE ABUSE PROFESSIONALS
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